ATTACHMENT I

EXAMPLES OF COMPLETED STD. 692

This section contains examples of the STD. 692 and how it is completed when a permitting event has occurred. The form will be completed differently depending on the permitting event and dates involved. To assist you in using these examples, each example also contains an explanation of the permitting event, type of action and enrollment status in Section E-18. (Remarks) You are not required to put a detailed explanation in the Remarks Section when completing the STD. 692. Refer to Attachment B for current dental rates information. The examples provided in this section do not reflect every possible type of dental transaction.

EXAMPLE 1

Permitting Event: New employee – Eligible represented employee
Type of Action: New enrollment
Permitting Event Code: 01
Permitting Event Date: 1/15/03 – Appointment date
Effective Date: Standard[1] – 60 days to file STD. 692

Note: As a represented employee, the employee is restricted to a prepaid plan unless they are in a bargaining unit that has accepted Consolidated Benefits (CoBen).

EXAMPLE 2

Permitting Event: New employee – Eligible excluded employee
Type of Action: New enrollment
Permitting Event Code: 01
Permitting Event Date: 8/1/03 - Appointment date
Effective Date: Standard – 60 days to file STD. 692

Notes: As an excluded employee, the employee is not restricted to a prepaid plan.

EXAMPLE 3

Permitting Event: Coverage loss as a dependent
Type of Action: New enrollment
Permitting Event Code: 05
Permitting Event Date: 2/28/03 – Date other coverage ended
Effective Date: Standard – 60 days to file STD. 692

[1] Standard effective date rule is dental benefits are in effect the first of the following month after the document is received in the personnel office.

EXAMPLE 4

Permitting Event:	Open enrollment period
Type of Action:	New enrollment
Permitting Event Code:	03
Permitting Event Date:	9/1/02 – Open enrollment start date
Effective Date:	January 1 of the following calendar year

Note: The employee has been employed for 24 months and is not restricted to a prepaid plan during this open enrollment period.

EXAMPLE 5

Permitting Event:	Permanent Intermittent (PI) employee worked required qualifying hours in January – June control period
Type of Action:	New enrollment
Permitting Event Code:	04
Permitting Event Date:	6/30/03 – End of control period
Effective Date:	First of the following month after STD. 692 is received by Personnel – 60 days to file STD. 692

Note: Effective date can be no earlier than August 1.

EXAMPLE 6

Permitting Event:	Represented employee completed 24-month restriction
Type of Action:	Change of plan
Permitting Event Code:	08
Permitting Event Date:	2/13/04 – Completion of 24-month restriction period
Effective Date:	Standard – 60 days to file STD. 692

Note: This example may also be used when a CAHP employee has completed the 24-month prepaid dental plan restriction period and is now eligible to enroll or change to the CAHP indemnity plan.

EXAMPLE 7

Permitting Event:	CCPOA employee completed 12-month restriction
Type of Action:	Change of plan
Permitting Event Code:	08
Permitting Event Date:	1/31/04 – Completion of 12 month restriction period
Effective Date:	Standard – 60 days to file STD. 692

EXAMPLE 8

Permitting Event:	Employee CBID change
Type of Action:	Change of plan
Permitting Event Code:	40
Permitting Event Date:	8/20/03 – Date of CBID change
Effective Date:	Standard – No time limit (Efforts should be made to file STD. 692 promptly)

EXAMPLE 9

Permitting Event:	Open enrollment period
Type of Action:	Change of plan and delete dependent(s)
Permitting Event Code:	29
Permitting Event Date:	9/1/02 – Open enrollment start date
Effective Date:	January 1 of the following calendar year

EXAMPLE 10

Permitting Event:	Divorce
Type of Action:	Delete ex-spouse
Permitting Event Code:	27a
Permitting Event Date:	4/1/03 – Divorce date
Effective Date:	Mandatory – No time limit (Efforts should be made to file STD. 692 promptly[2].)

Note: A copy of the final divorce decree is required. Offer spouse COBRA.

EXAMPLE 11(A)

Permitting Event:	Open enrollment period
Type of Action:	Cancel coverage
Permitting Event Code:	36a
Permitting Event Date:	9/1/02 – Open enrollment start date
Effective Date:	January 1 of the following calendar year

Note:

EXAMPLE 11(B)

Permitting Event:	Open enrollment period
Type of Action:	Add spouse
Permitting Event Code:	15
Permitting Event Date:	9/1/03 – Open enrollment start date
Effective Date:	January 1 of the following

[2] Divorce date means the court's order for final effective date of divorce – Date divorce becomes final

EXAMPLE 12 (Attachment J1)

Officers Separating from State Service as defined in Government Code Section 22816.7
Continuation of dental benefits through Delta Dental.

Permitting Event:
Separation

Type of Action:
Enrollment into Direct Pay Program as defined

Permitting Event Code:
None

Effective Date:
First of the following month after Separation

Example 1

DENTAL PLAN ENROLLMENT AUTHORIZATION

D

STD. 692 (REV. 6-2000)

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1 TYPE OF ACTION

✓ NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 123-45-6789

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First) Shamas (Middle) Kaneir (Last) Van der Groot

ADDRESS (Number and Street): 1234 Van Plas Ave.

(City, State, and Zip): Harmony , CA. 90321

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE

6. MARITAL STATUS: ___ MARRIED ✓ SINGLE ___ DOMESTIC PARTNER

7. SEX: ✓ MALE ___ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: SafeGuard

2. PROVIDER/FACILITY NUMBER *(If applicable)*: 12345 (Smile Anew Dental)

3 WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
A	Shamas K. Van der Groot	1	1	85	SELF

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

✓ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*: Signature Required

3. DATE SIGNED: Date Required

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150									
✓ NON-CSU-351	016	$ 0.00	1	$ 13.39	8	03	R	01	$ 13.39

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
CSU-150												
☐ NON-CSU-351			8	1	3	01	9	1	03	9999	99	State Agency Name

18. REMARKS: New Enrollment - Non-CoBen Rank and File Employee

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

Signature Required

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 123-4567

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 8 DAY 19 YEAR 03

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 6-2000)

Example 2

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1. TYPE OF ACTION

✓ NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 626-00-0000

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First) Juan (Middle) Carlos (Last) Valderama

ADDRESS (Number and Street): 123 Riverbone Blvd.

(City, State, and Zip): Sloughhouse, CA 95738

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: ☐

6. MARITAL STATUS: ☐ MARRIED ✓ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ✓ MALE ☐ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental Premier Enhanced

2. PROVIDER/FACILITY NUMBER *(If applicable)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
A	Juan Carlos Valderama	02	03	61	SELF

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

✓ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*: **SIGNATURE REQUIRED**

3. DATE SIGNED: **DATE REQUIRED**

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150									
✓ NON-CSU-351	008	$ 47.31	1	$ 0.00	8	03	E	98	$ 47.31

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
CSU-150												
☐ NON-CSU-351			8	1	3	01	9	1	03	999	99	State Agency Name

18. REMARKS

New Enrollment - Excluded Employee
Single - No Dependents
Not Restricted to Prepaid Plan

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

SIGNATURE REQUIRED

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 123-4567

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 8 DAY 19 YEAR 03

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

Example 3

D

STD. 692 (REV. 6-2000)

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1. TYPE OF ACTION

✓ NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 626-00-0000

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First) Charles (Middle) Henry (Last) Penn

ADDRESS (Number and Street): 38 Riverbone Blvd.

(City, State, and Zip): Sloughhouse, CA 95738

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE ☐

6. MARITAL STATUS: ☐ MARRIED ✓ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ✓ MALE ☐ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: SafeGuard

2. PROVIDER/FACILITY NUMBER *(If applicable)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
A	Charles Henry Penn	02	03	61	SELF

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

✓ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)* SIGNATURE REQUIRED

3. DATE SIGNED DATE REQUIRED

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150									
✓ NON-CSU-351	016	$ 13.39	1	$ 0.00	2	03	M	7	$ 13.39

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
CSU-150												
☐ NON-CSU-351			2	28	3	05	4	1	03	999	99	State Agency Name

18. REMARKS

New Enrollment - Coverage lost as dependent
Single - No Dependents

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

SIGNATURE REQUIRED

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 123-4567

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 3 DAY 18 YEAR 03

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

Example 4

D

STD 692 (REV 6-2000)

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

TYPE OF ACTION

/ NEW - ENROLLING IN A PLAN FOR THE FIRST TIME
(Complete Sections A, B, and D)

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES
(Complete Sections A, C, and D)

CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE
(Complete Sections A, B, C, and D)

2 SOCIAL SECURITY NUMBER: 222-33-4444

3 SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER: 999-88-7777

4. NAME (First) Bogg (Middle) Harry (Last) Powell

ADDRESS (Number and Street): 111 Longball Avenue

(City, State, and Zip): Genoa, CA 26111

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE

6. MARITAL STATUS: ✓ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ✓ MALE ☐ FEMALE

SECTION B

1 NAME OF DENTAL PLAN: Delta Dental

2 PROVIDER/FACILITY NUMBER *(If applicable)*

3 WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE (ADD) AND/OR (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH DAY YEAR	FAMILY RELATIONSHIP
A	Bogg H. Powell	02 15 56	SELF
A	Wilma A. Powell	03 20 58	Wife
A	Jason D. Powell	10 28 87	Son
A	Jill M. Powell	01 10 90	Dtr.

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

/ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*

Signature Required

3. DATE SIGNED: 09/15/2002

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED.CO DE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	6. PAY PERIOD YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150									
✓ NON-CSU-351	007	$ 22.46	3	$ 103.84	12	01	R	10	$ 126.30

COMPLETE ON CHANGES ONLY 10. PRIOR EMPLOYER DED.CO DE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH DAY YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
CSU-150								
☐ NON-CSU-351			9 1 2	03	1 - 1 - 03	222	012	State Agency Name

18. REMARKS

New Enrollment - Open Enrollment Period
Married - Three dependents
Not Restricted to Prepaid Plans

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

Signature Required

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (916) 414-5000

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 09 DAY 15 YEAR 02

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 6-2000)

Example 5

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1. TYPE OF ACTION

☑ NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

☐ CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

☐ CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 222-33-4141

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First) Sharon (Middle) Jane (Last) Stone

ADDRESS (Number and Street): 6161 Cable Way

(City, State, and Zip): Elitas, CA. 90302

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: ☑

6. MARITAL STATUS: ☑ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ☐ MALE ☑ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: PMI

2. PROVIDER/FACILITY NUMBER *(If applicable)*: 63210

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First)	(Middle)	(Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
A	Sharon	Jane	Stone	2	16	43	SELF
A	Eddie	Van	Stone	9	2	55	Spouse

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

☑ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*: SIGNATURE REQUIRED

3. DATE SIGNED: DATE REQUIRED

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150									
☑ NON-CSU-351	009	$ 0.00	2	$ 25.05	7	03	R	03	$ 25.05

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM *(IF RETIRED)*
CSU-150												
☐ NON-CSU-351			6	30	3	04	8	1	03	100	001	State Agency Name

18. REMARKS: P.I. enrollment after completion of control period

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

SIGNATURE REQUIRED

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 123-4567

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 7 DAY 03 YEAR 03

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

Example 6

STD. 692 (REV. 6-2000)

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

TYPE OF ACTION

NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

☑ CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 957-21-0123

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First) (Middle) (Last): Rosanne Mary Arnold

ADDRESS (Number and Street): 6025 Genoa Rd

(City, State, and Zip): Brentwood, CA. 90305

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: ☑

6. MARITAL STATUS: ☑ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ☐ MALE ☑ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental Premier Basic

2. PROVIDER/FACILITY NUMBER *(If applicable)*:

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
A	Rosanne M. Arnold	2	25	48	SELF
A	Jim P. Arnold	10	2	55	Spouse
A	Margo T. Barr	12	25	87	Dtr
A	John R. Barr	11	11	88	Son

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME:

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

☐ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*: SIGNATURE REQUIRED

3. DATE SIGNED: DATE REQUIRED

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150									
☑ NON-CSU-351	007	$ 29.00	3	$ 86.99	2	04	R	3	$ 115.99

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
CSU-150												
☐ NON-CSU-351			2	13	4	08	3	-1-	04	010	012	State Agency Name

18. REMARKS

Change of Dental Plan - Represented Employee
Completion of 24-month restriction
Date of hire: 2/13/02

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 123-4567

21. DATE RECEIVED IN EMPLOYING OFFICE MONTH: 2 DAY: 20 YEAR: 04

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

Example 7

STD. 692 (REV. 6-2000)

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1. TYPE OF ACTION

NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

☑ CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 333-44-5555

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First) Jackson (Middle) R (Last) Gomes

ADDRESS (Number and Street): 112 Capitola Way.

(City, State, and Zip): Salinas, CA. 94831

5. ☐ CHECK IF PERMANENT INTERMITTENT EMPLOYEE

6. MARITAL STATUS: ☐ MARRIED ☑ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ☑ MALE ☐ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: CCPOA (Primary Dental Plan)

2. PROVIDER/FACILITY NUMBER *(If applicable)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
A	Jackson R. Gomes	2	15	43	SELF

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME: CCPOA Western Dental

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

☑ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*: SIGNATURE REQUIRED

3. DATE SIGNED: DATE REQUIRED

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150 / ☑ NON-CSU-351	006	$ 25.00	1	$ 44.33	2	04	R	6	$ 69.33

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM *(IF RETIRED)*
CSU-150 / ☐ NON-CSU-351			1	31	4	08	3	1	04	020	111	State Agency Name

18. REMARKS

Change of Dental Plan - R06 Employee
Completion of 12 month restriction period

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

SIGNATURE REQUIRED

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 123-4567

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 2 DAY 25 YEAR 04

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

Example 8

D

STD. 692 (REV. 6-2000)

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1. TYPE OF ACTION

NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

☑ CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 765-43-1298

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First) (Middle) (Last): Rex R Chapman

ADDRESS (Number and Street): 1000 Rain Water Dr.

(City, State, and Zip): Calipatria, CA. 97831

5. ☐ CHECK IF PERMANENT INTERMITTENT EMPLOYEE

6. MARITAL STATUS: ☐ MARRIED ☑ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ☑ MALE ☐ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental Premier Enhanced

2. PROVIDER/FACILITY NUMBER *(If applicable)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First)	(Middle)	(Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
A	Rex	R	Chapman	7	8	52	SELF

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME: CCPOA Western Dental

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

☑ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*: SIGNATURE REQUIRED

3. DATE SIGNED: DATE REQUIRED

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150									
☑ NON-CSU-351	008	$ 47.31	1	$ 0.00	10	03	S	6	$ 47.31

COMPLETE ON CHANGES ONLY: 10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
CSU-150												
☐ NON-CSU-351			8	20	3	40	11	1	03	001	989	State Agency Name

18. REMARKS

Change in Bargaining Unit
Change from Union Plan to State Plan

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

SIGNATURE REQUIRED

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 123-4567

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 10 DAY 10 YEAR 03

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

Example 9

D

STD 692 (REV 6-2000)

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

TYPE OF ACTION

NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C and D)*

✓ CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 111-22-3333

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER: 414-00-9999

4. NAME (First): Ann (Middle): Lana (Last): Turner

ADDRESS (Number and Street): 55 Marve Road

(City, State, and Zip): Tilley, CA 41111

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: ☐

6. MARITAL STATUS: ✓ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ☐ MALE ✓ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: PMI

2. PROVIDER/FACILITY NUMBER *(If applicable)*: 210695

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD), A CODE D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH DAY YEAR	FAMILY RELATIONSHIP
	Ann L. Turner	10 15 47	SELF
	Mark N. Turner	06 12 45	Husband
	Mike R. Turner	05 11 70	Son
D	Angie C. Turner	06 10 71	Dtr
D	Scott D. Turner	11 11 75	Son

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME: Safeguard

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

✓ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANTS SIGNATURE *(See Privacy Information on reverse of employee copy.)*: Signature Required

3. DATE SIGNED: 09/10/2002

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED.CO DE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	6. PAY PERIOD YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150 ☐ NON-CSU-351 ✓	009	$ 0.00	3	$ 34.65	12	02	E	88	$ 34.65

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED.CO DE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
CSU-150 ☐ NON-CSU-351			9	1	2	29	1	1	03	001	016	State Agency Name

16. REMARKS: Change of plans and delete dependents during open enrollment.

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

Signature Required

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (600) 455-2500

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 09 DAY 10 YEAR 02

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

Example 10

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV 6-2000)

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

TYPE OF ACTION

NEW - ENROLLING IN A PLAN FOR THE FIRST TIME
(Complete Sections A, B, and D)

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES
(Complete Sections A, C, and D)

✓ CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE
(Complete Sections A, B, C, and D)

2. SOCIAL SECURITY NUMBER: 777-77-7777

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First) Todd (Middle) R. (Last) May

ADDRESS (Number and Street): 7 Long Blvd.

(City, State, and Zip): Daytona, CA 00007

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: ☐

6. MARITAL STATUS: ☐ MARRIED ✓ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ✓ MALE ☐ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental

2. PROVIDER/FACILITY NUMBER *(If applicable)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH DAY YEAR	FAMILY RELATIONSHIP
	Todd R. May	12 25 57	SELF
D	Megan C. May	11 10 55	Ex-Wife

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME:

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

✓ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONSTO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*

Signature Required

3. DATE SIGNED: 04/07/2003

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED.CO DE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH / YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150								
✓ NON-CSU-351	007	$ 10.12	1	$ 30.20	4 / 03	R	04	$ 40.32

COMPLETE ON CHANGES ONLY								
10. PRIOR EMPLOYER DED.CO DE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH DAY YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM *(If RETIRED)*
CSU-150								
☐ NON-CSU-351			4 1 3	27a	5 1 03	111	222	State Agency Name

18. REMARKS

Employee deletes ex-wife due to divorce.
Mandatory deletion.

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

Signature Required

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (222) 333-4444

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 04 DAY 07 YEAR 03

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

Example 11 (A)

D

STD 692 (REV 6-2000)

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1 TYPE OF ACTION

NEW - ENROLLING IN A PLAN FOR THE FIRST TIME
(Complete Sections A, B, and D)

✓ CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES
(Complete Sections A, C and D)

CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE
(Complete Sections A, B, C, and D)

2 SOCIAL SECURITY NUMBER: 878-65-1111

3 SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER: 555-44-8888

4. NAME (First): Wesley (Middle): D. (Last): Snipes

ADDRESS (Number and Street): 46 Midyo Street

(City, State, and Zip): Pastisas, CA 11112

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: ☐

6. MARITAL STATUS: ✓ MARRIED ☐ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ✓ MALE ☐ FEMALE

SECTION B

1 NAME OF DENTAL PLAN

2 PROVIDER/FACILITY NUMBER *(If applicable)*

3 WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE (ADD AND/OR DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED AND/OR DELETED

ACTION	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First)	(Middle)	(Last)	DATE OF BIRTH MONTH DAY YEAR	FAMILY RELATIONSHIP
					SELF

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME: Delta Dental

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

☐ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

✓ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANTS SIGNATURE *(See Privacy Information on reverse of employee copy.)*: Signature Required

3. DATE SIGNED: 09/01/2002

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED.CO DE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150									
✓ NON-CSU-351		$		$	12	02			$

COMPLETE ON CHANGES ONLY									
10. PRIOR EMPLOYER DED.CO DE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH DAY YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH DAY YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
CSU-150								
✓ NON-CSU-351	007	3	9 1 2	36a	1 - 1 - 03	123	987	State Agency Name

18. REMARKS

Cancel Coverage
Enrolling on spouse's plan during open enrollment.
Flex Cash Option: Attach STD 701C

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

Signature Required

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 998-1001

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 09 DAY 01 YEAR 02

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

Example 11 (B)

D

STD. 692 (REV. 6-2000)

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY--SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

TYPE OF ACTION

NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

CANCEL - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

✔ CHANGE - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER: 555-44-3333

3. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER:

4. NAME (First): Vansessa (Middle): M. (Last): Snipes

ADDRESS (Number and Street): 46 Midyo St.

(City, State, and Zip): Pastisas, CA. 92001

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE: ☐

6. MARITAL STATUS: ☐ MARRIED ☑ SINGLE ☐ DOMESTIC PARTNER

7. SEX: ☑ MALE ☐ FEMALE

SECTION B

1. NAME OF DENTAL PLAN: Delta Dental Premier Enhanced

2. PROVIDER/FACILITY NUMBER *(If applicable)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
	Vanessa M. Snipes	2	2	62	SELF
A	Wesley D. Snipes	5	6	60	Spouse

SECTION C (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN *(Keep in employee's file)*

☐ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*: **SIGNATURE REQUIRED**

3. DATE SIGNED: 09/01/2003

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE or COBEN DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH	YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
CSU-150 ☐ NON-CSU-351 ☑	008	$ 94.03	2	$ 0.00	12	02	M	02	$ 94.03

COMPLETE ON CHANGES ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	PRIOR PARTY CODE	12. PERMITTING EVENT DATE MONTH	DAY	YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH	DAY	YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM *(IF RETIRED)*
CSU-150 ☐ NON-CSU-351			9	1	3	15	1	1	04	123	987	State Agency Name

18. REMARKS

Add spouse during open enrollment
spouse enrolling in FlexElect Cash option during open enrollment
Attach spouse's STD 701 C an dcancellation STD 692
COBEN employee

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

SIGNATURE REQUIRED

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*: (555) 123-4567

21. DATE RECEIVED IN EMPLOYING OFFICE: MONTH 09 DAY 01 YEAR 03

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee